



Vaccines For Children Program

Local Health Department

VACCINE INVENTORY & ORDER FORM

Fax to: (410) 333-5893

PIN (required): _____ **LHD Name:** _____ **Date:** ____/____/____

Delivery Address (if new): _____

Contact Name: _____ **Phone #:** _____ **Email:** _____

Fax #: _____ **Special Delivery Instructions:** _____

VACCINE	TOTAL # OF VFC DOSES ON HAND	# OF VFC DOSES REQUESTED	VACCINE	TOTAL # OF VFC DOSES ON HAND	# OF VFC DOSES REQUESTED
DTaP			PCV13 (Pneumococcal Conjugate)		
DTaP/HepB/IPV (Pediarix)			MCV4 (Meningococcal Conjugate)		
DTaP/Hib/IPV (Pentacel)			Hepatitis A		
DTaP/IPV (Kinrix)			Rotavirus		
Tdap			HPV (Human Papillomavirus)		
Hib			DT		
Hepatitis B			Td Adult		
MMR			PPV23		
Polio			Hiberix		
Varicella					

Vaccine delivery can be expected approximately 2 weeks after faxing.

INSTRUCTIONS:

1. This form is for use by Maryland Local Health Departments only.
2. Your VFC provider identification number (PIN) is required with every inventory submission.
3. Indicate your vaccine delivery address if it has changed since the last inventory submission.
4. If applicable, describe any special delivery instructions (i.e., no delivery on Wednesday).
5. Write in the TOTAL number of doses of each VFC vaccine type (regardless of brand name) you currently have.

For example: 10 doses of Daptacel and 40 doses of Infanrix =
50 total doses on hand of DTaP.

Indicate the TOTAL number of doses requested for each dose of vaccine.
Please note: vaccine order requests will be based on vaccine availability.

6. To revise your vaccine brand preference please contact your VFC Consultant.
Please note: vaccine order requests will be based on vaccine availability.
7. Fax this form to the Maryland Vaccines for Children Program at (410) 333-5893.
8. Please do not use any previous versions (before August 2010) of this form.